EXHIBIT 5

CASCADE ORTHOPEDICS, P.C.
1715 East 12th Street
The Dalles, Oregon 97058

HINMAN, Talia E. **NEW PATIENT** **DOB: 05/15/1987**

DATE OF SERVICE: **December 12, 2003**

CHIEF COMPLAINT: Low back and bilateral hip pain.

HISTORY OF PRESENT ILLNESS: She is a 16-year-old female who is a pitcher in softball and has a very tortuous landing position and injured her left hip originally in March. She felt pain over her greater trochanter. She tried pitching some more and had extreme pain. She waited a few games to get it to calm down and then back to pitching. Subsequently it began hurting again and then her right hip began hurting in the same location. Subsequently she quit playing softball at the end of the season and now she has aching low back pain. She went on to have an MRI of her hips in October of this year. She is here for evaluation. She denies any weakness, numbness, or tingling. She denies any bowel or bladder problem. She has undergone acupuncture and chiropractic manipulation, with minimal improvement.

ALLERGIES: None.

MEDICAL CONDITIONS: None.

MEDICATIONS: None.

PREVIOUS INJURIES: Broken collarbone and broken ankle.

SOCIAL HISTORY: Patient is single, lives with her parents. She is a nonsmoker and a nondrinker. Her review of systems is noncontributory.

PHYSICAL EXAMINATION: The patient is able to forward flex 90 degrees without difficulty and extend fully. She is able to heel walk and toe walk without difficulty. She has painless passive range of motion of the hips. She has 5/5 motor strength with hip flexion bilaterally, but resisted hip flexion causes extreme discomfort on the left worse than the right. She has 5/5 motor strength with knee flexion, knee extension, dorsiflexion, plantarflexion of the ankle and EHL bilaterally. She has trace tendo Achilles and patellar tendon reflexes bilaterally. She has no clonus. She has negative straight-leg raise bilaterally. Physical examination shows point tenderness over the greater trochanters bilaterally and exquisite discomfort with palpation of the lesser trochanter on the left hip.

MRI EXAMINATION: MRI is reviewed which shows some intrapelvic fluid, appears to be a ruptured ovarian cyst. No significant hip pathology noted.

IMPRESSION: IRRITATION OF THE ILIOPSOAS, LEFT WORSE THAN RIGHT, AND BILATERAL MILD TROCHANTERIC BURSITIS WITHOUT MRI EVIDENCE OF INFLAMMATION.

TREATMENT PLAN: Conservative therapy. Stretching exercises were advised. I believe that the intrapelvic fluid may be leading to part of her iliopsoas irritation. I advised her to proceed with this conservative care and if her symptoms worsen in any way, then she should contact either myself or Clara DeLeon to discuss the situation.

Gregory M. Stanley, MD

EXHIBIT 5
PAGE 1

CASCADE ORTHOPEDICS, P.C.
1715 East 12th Street
The Dalles, Oregon 97058

DATE OF SERVICE: **March 31, 2004**

Talia is here in follow-up regarding her bilateral hip pain.

HISTORY OF PRESENT ILLNESS: The patient is a 16-year-old female who I evaluated back in December and noted she had irritation of the iliopsoas tendon on the left worse than the right at that time. She had a pelvic MRI which showed some fluid from a ruptured ovarian cyst, and there was a question if there was a correlation. She has held off for several months from her activities and has gone back to softball and has extremely disabling pain in her bilateral hips, now affecting her right abductor musculature as well. She is extremely upset that she is not able to perform her favorite activity.

PHYSICAL EXAMINATION: On exam, Talia has decreased lumbar lordosis. She is able to forward flex and touch her toes without significant difficulty. Internal and external rotation of the hips causes significant discomfort bilaterally and with direct pressure on the iliopsoas tendon bilaterally, she has exquisite discomfort. There is a small palpable snap on both iliopsoas tendons which is uncomfortable to her as well. She has some mild trochanteric and abductor discomfort on the right hip.

IMPRESSION: BILATERAL ILIOPSOAS BURSITIS AND SUBSEQUENT RIGHT TROCHANTERIC BURSITIS TYPE OF PICTURE.

TREATMENT PLAN: I have given Talia some exercises today and recommend anti-inflammatory regimen to try and give this best chance of quickest recovery. I have given her the information that I believe this will recover in time, but the time line may not correspond with what her hopes are. There are other known interventions such as bursogram, injections, etc. We discussed those at length today. She will contact us in approximately four weeks to let us know how she is going with the current plan. If she is not doing well, then we would consider proceeding with a more progressive intervention.

Gregory M. Stanley, MD

cc: Michael Pendleton, MD

EXHIBIT 5
PAGE 2

PEDIATRIC GASTROENTEROLOGY & NUTRITION
MELISSA BURCHETT, PNP
PEDIATRIC NURSE PRACTITIONER
www.pedsgastro.yourmd.com

SUITE 335
501 N.GRAHAM ST.
PORTLAND, OR. 97227

OFFICE
(503) 281-5139
Fax (503) 249-3782

April 27, 2004

Tony Gay, M.D.

RE: **Talia Hinman**
DOB 5/15/1987

Dear Dr. Gay:

I had the pleasure of seeing Talia with her mother in my office for the first time April 27, 2004. As you know, Talia is a 16-almost-17-year-old young lady who has been ill for 2-1/2 to 3 months. This illness started sometime in January. She recalls her family and a couple of her friends being ill with what seemed to be a flu-type virus, which consisted of nausea, vomiting, and diarrhea. Everyone seemed to get better except for Talia. She continued to have generalized abdominal pain, vomiting after every meal, and fairly persistent nausea. She states that she was just drinking fluids for about 2 weeks as she could not keep any solids down. She was evaluated, felt to have sinusitis with post-nasal drip, and placed on an antibiotic. While on antibiotics for sinusitis, her symptoms seemed to fairly completely resolve. Once off of the antibiotics she had a relapse of her abdominal pain, vomiting, and nausea. The vomiting, although, was not as severe. She was restarted on antibiotic therapy, but her symptoms did not subsequently subside. She has continued with persistent nausea, abdominal pain that is generalized and waxes and wanes in severity. She has developed new symptoms of chronic headache in her temples and occiput. She states it is always there but certainly increases in severity on occasion. There seem to be no exacerbating factors. Light does make her headache worse. She feels that her vision has been a bit blurred over the last week or so. She otherwise has had no visual changes. She continues to have abdominal pain. Vomiting is less, and she is keeping some foods down at this point. She may vomit several times a week but certainly not daily. She also complains of lightheadedness and dizziness anytime she goes from a sitting or lying position to standing. She also is experiencing some vertigo when lying in bed. Her mother noted some easy bruising a few weeks ago, but this seems to have resolved. She also complains of a right tonsillar lymph node enlargement, decreased appetite, inflamed taste buds, low-grade fever of 99-100 degrees, and very significant fatigue. She states she has been constipated. Has had no diarrhea. She has not noted any blood in her stool or vomiting. She has had no bilious vomiting. She is sleeping anywhere from 15-20 hours a day. She is having unusual dreams. She states that she has had a 20-pound weight loss. From the information I have from your office, I can confirm a documented 10-pound weight loss. This has been over one month's time. Workup to date has been fairly extensive. She has had a CBC, Monospot, chemistry panel, amylase, and an H. pylori screen, which have all been unremarkable. She had a repeat basic metabolic panel and thyroid studies, which were normal. Urinalysis showed slightly elevated protein but was otherwise normal. Urine pregnancy x 2 has been unremarkable. CT of the abdomen was normal. CT of the sinuses was normal. Enhanced head CT was normal. Follow-up unenhanced head CT not

EXHIBIT 5
PAGE 3

done. Additionally, she had an MRI of her hips 4 months ago, and mother reports that the MRI showed ovarian cysts and some free pelvic fluid. I do not have this report today. She was placed on oral contraceptive pills, and this has not alleviated her symptoms. She was taken off, and her symptoms again have not changed. She has been tried on Protonix 40 mg daily since the end of March. This has made no difference in her symptoms. Pepto-Bismol, Mylanta, Tylenol, and Advil do not alleviate her abdominal pain or headache. She is quite frustrated with not feeling well. She has a difficult time getting to school. She is generally making half days in the afternoon but has difficulty getting to school in the mornings. She has had to call her mother on several occasions to come pick her up while driving as she did not feel well enough to drive. She generally is a very active outgoing young lady who is very active in sports. She has been missing softball and social activities related to her discomfort. She and her mother are quite anxious and would like to see if we can help shed some light on her symptomatology.

Talia has been a very healthy young lady throughout her life. She has had no surgeries, major illnesses. She has had no hospitalizations. She has had a broken collarbone, foot, and bursitis in her hips. She currently is taking no medications. She has no known allergies to foods or medications. Her immunizations are up to date.

Talia lives at home with her mother and stepfather. Has a half-brother with whom she does not have contact. There are older stepsiblings who are out of the house. She has a dog, cat, rabbit, and 2 horses but no other pets. They live on at orchard, and there are sprays utilized to control pests. They drink bottled water. Most recent travel was to Florida one year ago for spring break. Two years ago she visited Tonga and France. She is currently sexually active but is in a monogamous longstanding relationship. She occasionally has a cigarette. There is a history of marijuana use but none within the last 8 months. There seem to be no significant changes in her life or stressors other than related to her current illness and not feeling well.

Talia is typically a very healthy young lady who chooses to eat fruits and vegetables over fast food products. She generally drinks water throughout the day and consumes adequate amounts. Her appetite has been decreased over the last couple of months.

Review of systems is as previously described. In addition, she also complains of some joint pain in her hips, knees, and ankles. Menstrual cycles prior to starting oral contraceptives were very close together but not particularly heavy or painful.

Family history is significant for maternal grandmother passing away with Hodgkin lymphoma. Mother has a pituitary tumor but is otherwise healthy. Maternal great-grandparents both died very early of cancer. The great-grandmother had brain cancer. Great-grandfather's type of cancer is unknown. Family history on the paternal side of the family is unknown, as father has been estranged from Talia since very early in her life.

Talia is in no acute distress during today's exam. She sits easily in the chair and moves comfortably about the room. She is well groomed. She is thin but does not appear to be malnourished. She weighs 122.5 pounds today, putting her at the 50th percentile. Her height is 67-3/4, putting her between the 90th and 95th percentiles. Pulse 82, respirations 20, blood pressure 112/58. HEENT, lung, and cardiac exams are unremarkable. There is a pit on her left posterior pinna (congenital abnormality). Abdomen is soft, nondistended with no organomegaly or palpable masses. She does complain of some generalized tenderness, more so midline above her umbilicus to the xiphoid process and extending over along the left costal margin. Anus shows normal placement, sphincter tone, and a positive anal wink. Perianal skin is

unremarkable. Digital rectal exam reveals a nonrestrictive rectal vault with a scant amount of soft heme-negative stool. She has no tenderness with palpation of the rectum. She does have a bruise noted at the top of her right superior posterior iliac crest and a palpable mobile nodule underneath the skin, probably a fatty cyst. Deep tendon reflexes are 2+ and symmetric in upper and lower extremities. Joints and spine demonstrate full range of motion without swelling or tenderness today. Skin is grossly intact. She does have 2 cafe au lait birth marks noted, I believe, to the left of her spine in her lumbar region and one at the perineal area. Otherwise skin is grossly intact.

Talia certainly has quite the menagerie of symptoms and has not been feeling well now for 2-1/2 months. Her symptoms are interfering with her quality of life and ability to perform normal activities. Her symptoms do not point to any one specific gastrointestinal problem. They actually sound more like somatic complaints consistent with a functional condition. To help further evaluate the situation, however, we would like to perform an upper endoscopy with biopsies. She will return for an unenhanced CT of her head. I reviewed her symptoms with Dr. Marshall, who feels that upper endoscopy is an appropriate evaluation at this time to help provide some reassurance that there is not significant underlying gastrointestinal pathology. She will be returning on Friday, April 30th, to have an upper endoscopy with biopsies under conscious sedation with Dr. Marshall. PARQ conference was performed, and informed consent was obtained. Hopefully will have the results of her CT scan at that time and can review them while she is here. She should call 2-3 days after the endoscopy to review the results of the biopsy.

I appreciate your referral of this nice family. If you have any questions or concerns, please call. Thank you.

Sincerely,

Melissa K Burchett

Melissa Burchett, P.N.P.

MB/cjk

EXHIBIT 5
PAGE 5

MS

April 23, 2004

COLUMBIA GORGE E.N.T.
AND ALLERGY

Tony Gay, M.D.
1108 June Street
Hood River, OR 97031

RE: Talia Hinman
DOB: 5/15/87

Dear Dr. Gay:

Thank you very much for your referral of Talia Hinman. I reviewed her symptoms in detail with her and her mother today. I also reviewed the notes from your office, which were quite helpful. Talia's main complaint is frequent vomiting and stomach aches. This started approximately two months ago, and seems to be worse in the evening, although it can occur at any time throughout the day. She tells me that she has been unable to attend school for several weeks because she feels that the vomiting is actually quite unpredictable. On close questioning, she admits that the vomiting is more like a water brash sensation of reflux of gastric contents into the pharynx, which she will then spit out. This definitely seems to be more likely to occur after she has eaten, although it will also occur first thing in the morning. Her mother tells me that she has had a 20-pound weight loss in the last two months, although from the notes in your office, it appears that she has decreased from approximately 144 pounds in February to her most recent weight of 128 pounds. She also is experiencing a chronic feeling of postnasal drip and the sensation that something is caught in her throat. Her mother mentions that Talia frequently feels warm to the touch, but they have not taken her temperature. At one point, she was treated with a course of a proton pump inhibitor, which they think was Protonix, which stopped the vomiting for ten days. However, it recurred despite taking the PPI. She has subsequently stopped taking that. She has also had an h. Pylori test which was negative, a CT scan of the head, which was negative, a CT of the sinuses which was negative, mono test which was negative, blood work which showed mild electrolyte imbalance consistent with vomiting. Her mother also notices that Talia appears to be extremely fatigued. She has not noted any signs of obstructive sleep apnea. Talia describes the headaches as being bi-temporal, and she will frequently awaken with these. She notes that if she does not awaken with a headache, she will occasionally develop one later in the day.

On examination: This is a well-developed, well-nourished female in no acute distress. Extra-ocular muscles are intact. Pupils are equal, round, and reactive to light and accommodation. Tympanic membranes are mobile. Nasal cavity examination is unremarkable. Oral cavity examination shows marked posterior pharyngeal wall cobblestoning, with prominent lymphoid hypertrophy in the posterior pharynx. Laryngeal examination shows extreme laryngeal mucosal erythema (grade III), with grade III interarytenoid pachydermia, and grade II edema of the vocal folds themselves. The vocal folds are not erythematous. The neck is without adenopathy or thyroid mass. The temporomandibular joints are exquisitely tender to palpation bilaterally. There is crepitus in the joints bilaterally with opening and closing of the jaw.

EXHIBIT 5
PAGE 6

LEIGH ANNE DEW M.D.
BOARD CERTIFIED OTOLARYNGOLOGIST
1790 MAY ST • HOOD RIVER, OR 97031 PHONE: 541.386.5119 FAX 541.298.7746
1815 E 19TH, STE 1 • THE DALLES, OR 97058 PHONE: 541.298.5563 FAX 541.298.7746

MAY 03 2004

ajn

PEDIATRIC GASTROENTEROLOGY & NUTRITION

MELISSA BURCHETT, PNP

www.pedsgastro.yourmd.com

SUITE 335
501 N.GRAHAM ST.
PORTLAND, OR. 97227

OFFICE
(503) 281-5139
Fax (503) 249-3782

5/24/04

TONY GAY, MD
1108 JUNE ST.
HOOD RIVER, OR. 97031

Re: TALIA HINMAN STIPAK
DOB: 5/15/87

Dear Dr. GAY:

Your patient TALIA HINMAN STIPAK visited my office again on 5/24/04. TALIA is a 17 year old female who carries the following diagnoses:

ABDOMINAL PAIN, GENERAL 78907
Weight Loss 78321
Vomiting w/ Nausea 78701

Subjective:
Talia returns today with questions. She continues to do poorly. She was seen by a neurologist (I believe Dr. Weller) who is assisting in her work-up. Her symptoms are perplexing with no identifiable cause as of yet. Talia was on Augmentin for possible sinusitis up until three days prior to her EGD. There is a concern that antibiotic use this close to the EGD would have negated the screening for H.pylori. They want to know if they should be concerned about a missed H.pylori infection. Talia is currently taking Nexium 40 mg daily but no other medications.

Objective:
Wt. 123.5 lb which demonstrates a one pound weight gain since our visit 4/26/04. Pale and appears tired. PE not done.

Assessment:
Abdominal pain, nausea, and emesis without obvious source.

Plan:
Case was reviewed with Dr. Marshall. Performing biopsies when a person has been on no antibiotics for 30 days is ideal, but not an absolute necessity. Amoxicillin alone would not be enough to erradicate H. pylori so it is highly unlikely that the biopsies were falsely negative and we do not feel this should be considered in the differential diagnosis at this time. Her serum H.pylori antibody testing was also negative. Being negative at this time also does not preclude her from acquiring H. pylori in the future.

EXHIBIT 5
PAGE 7

I am grateful for your continuing support. Thank you for allowing me to participate in this young lady's care.

Sincerely,

Melissa K Burchett

Melissa Burchett, PNP

EXHIBIT 5
PAGE 8

NG

Jeffrey J. Brown, MD, PhD
David F. Cobasko, MD
Chris J. Ginocchio, MD
M. Sean Green, MD
Kirk L. Weller, MD

Neurology Consultants

May 10, 2004

Anthony S. Gay, M. D.
1108 June Street
Hood River, OR 97031

RE: HINMAN, Talia E.

Dear Doctor Gay:

Thank you for the referral on Talia Hinman whom I saw today regarding headaches complicated by an overall degree of malaise, weight loss and flu-like symptoms that have been present since around February.

She is a 16-year old young lady who is accompanied by her mother. Apparently she became ill in February at about the same time her mother did. This was felt to be a flu. She had a fever, nausea, vomiting, stomach pain but this progressed into a constant but variable headache with migrainous features much of the time. There have not been any overt neurologic symptoms. Her workup has been detailed including a visit to ENT which included evaluation for possible allergy issues as I understand. She has seen a gastroenterologist with endoscopy. She has had multiple blood tests, CT of the abdomen, and CT of the head and sinuses. As I understand, the only thing that has come back somewhat abnormal was her recent CBC April 14, 2004, at Providence Hood River Memorial. This showed a normal CBC except for a differential showing 27 neutrophils and 60 lymphocytes (normally, there is 36 to 66% neutrophils and 24 to 44% lymphocytes).

While she has had some travel including to Tonga, none of this has been in the last year except for a visit to Southern California and Tonga two years ago. Her mother came back sick and was on Cipro for some period of time but this was not a persistent issue for anyone.

She has been sexually active and has been on birth control pills but those were stopped briefly to see if that benefited her. This did not provide much benefit. She has been HIV negative six months ago but as far as I can tell, this has not been checked recently.

Portland Office
501 N Graham – Suite 515
Portland Oregon 97227
(503) 282-0943

Gresham Office
24900 SE Stark – Suite 211
Gresham Oregon 97030
(503) 669-0435

EXHIBIT 5
PAGE 9

MAY 14 2004

REVIEW OF SYSTEMS:
Continuing low-grade fever. She states lately her oral temperatures have been around 99 degrees Fahrenheit. Sweats, weight loss, fatigue, dizziness, headache, blurred vision, sensitivity to light during her headaches. Eye pain during her headaches. Ringing in the ears. Dizziness, cramps, weakness, balance, trouble walking, joint swelling, diarrhea, constipation, nausea, vomiting, menstrual irregularity, sleep disturbance, hot/cold intolerance, anxiety, depression, spine pain, pain into the hips which she describes as bursitis.

PRIOR MEDICAL HISTORY:
Left blank.

SURGICAL HISTORY:
None.

MEDICATION ALLERGIES:
None.

CURRENT MEDICATIONS:
Nexium.

FAMILY HISTORY:
Father is deceased. Mother is 43. Family members have had cancer.

SOCIAL HISTORY:
She is in junior high. She is single. She gets regular exercise usually. She considers her stress to be moderate. She quit cigarettes two months ago and uses no alcohol.

PHYSICAL EXAMINATION:
Generally, this is a somewhat pallid appearing, perhaps slightly ill young woman who is tall in stature but quite thin for her stature.

HEENT: Unremarkable. Neck is supple with full range of motion and no Spurling's sign. There is no tenderness.

Mental Status: Alert and oriented with fluent speech following all commands and incorporating information with good insight. She appears tired.

Cranial Nerves, II through XII: Fully tested and found intact.

EXHIBIT 5
PAGE 10

Motor Examination: Symmetric forearm rolling motion with full power tests directly throughout. There is no evidence of fasciculation, atrophy or change in tone.

Coordination: Tests on finger-to-nose and rapid alternating motions are intact.

Sensory Examination: Tests distally are intact to light touch.

Reflexes: Deep tendon reflexes are in the range of 1 to 2/4 symmetrically in biceps, triceps, and brachioradialis, knee and ankle jerks. Plantar reflexes are downgoing.

Gait: Gait shows a stable narrow-based gait with no evidence of ataxia, spasticity, asymmetry or weakness. The patient can walk on heels, toes, and perform a tandem gait and standard Romberg without abnormalities.

IMPRESSION:

(1) Normal neurologic examination.
(2) Chronic daily headache with migrainous features at times.
(3) I do think her headaches are associated with a more systemic illness, possibly viral, conceivably metabolic or hematologic.

RECOMMENDATIONS:

(1) I would like her to get a MRI with and without contrast simply out of the fact that she has had new onset prolonged intractable headaches. The fact that she has had a normal head CT does not obviate that need.
(2) I am sending for several blood tests to include a repeat CBC with differential, ANA, sed rate, serum protein electrophoresis, Vitamin D 25 hydroxy level, Lyme antibody titer.
(3) I am giving her samples of triptan migraine medications to see if these might benefit what appear to be significant migraines at times.
(4) I would like to see her back in 1-1/2 to 2 weeks to see if these tests prove at all concerning, and possibly consider a lumbar puncture. We might include with that a VDRL and cryptococcal antigen, and if there is elevated white count, a rather detailed infectious disease screening.

EXHIBIT 5
PAGE 11

Let me know if you have questions. I appreciate the request.

Sincerely yours,

Kirk L. Weller, M. D.

KLW:vo

EXHIBIT 5
PAGE 12

Jeffrey J. Brown, MD, PhD
David F. Cobasko, MD
Chris J. Ginocchio, MD
M. Sean Green, MD
Kirk L. Weller, MD

Neurology Consultants

May 24, 2004

Call from/pt.

Anthony S. Gay, M. D.
1108 June Street
Hood River, OR 97031

RE: HINMAN, Talia E.

Dear Doctor Gay:

[redacted]

In followup with Talia Hinman, I saw her again today with her having the MRI performed at East Portland Imaging May 10, 2004. This did reveal a normal MRI which is very reassuring especially since it was also done with contrast. Brain MRI

She returns continuing to have significant headaches and has many questions. Laboratories which I had ordered were performed in Hood River but I only received the Lyme antibody titer and a CBC. I saw from notes her mother carries that ANA was performed and this was apparently normal. It is uncertain to me whether the sed rate, serum protein electrophoresis or Vitamin D levels were normal. Again, this is because they did not return the report to me.

She did not try triptan medications despite having had several migraines because she feels they might sedate her. They will not sedate her but, nonetheless, she did not try them.

You felt that amitriptyline might be helpful and provided her a prescription with that medication written on it, thus, so we could discuss that. You also offered to have her see a counselor though she seems to feel that psychiatric or psychological issues are probably not primary.

They continue to be concerned about diarrhea and apparently low-grade fevers. She has had a GI workup with Doctor Marshall and at some point in the prior weeks she has had a gastric biopsy for H. pylori or so I understand. Talia's mother is concerned that was done too recently after amoxycillin had been provided and that it may have been insensitive therefore. They were reassured about this but they still have lingering uncertainties about it.

Portland Office
501 N Graham – Suite 515
Portland Oregon 97227
(503) 282-0943

Gresham Office
1900 SE Stark – Suite 211
Gresham Oregon 97030
(503) 669-0435

EXHIBIT 5
PAGE 13

JGTO

JUN 0 1 2004

Anthony S. Gay, M. D.
RE: Talia E. Hinman
May 24, 2004
Page 2

They are reassured about the MRI but have continuing concerns about the "cause" as opposed to simply treating symptoms of headache.

We discussed spinal fluid studies. Talia herself seemed quite hesitant especially when I suggested that the likelihood of this being abnormal is quite low. Indeed, I would add the likelihood of having a treatable infectious entity is quite low. We would be entertaining something that would cause both diarrhea and headaches.

Examination is deferred due to lack of any new neurologic symptoms (they were over about 20 minutes late).

IMPRESSION:
Migrainous headaches complicated by patient's decision-making in utilizing my previously prescribed therapies (avoiding triptans in the assumption that they cause sedation, etc.)

PLAN:

(1) I think it would be reasonable to get a second opinion from a gastroenterologist here. I would like her to see Doctor Albaugh as I do think dealing an explanation of her fevers and diarrhea is probably center to this whole situation. Certainly, most things that might prompt that kind of problem could cause headaches or at least that is my intuition here.

(2) I have offered her a spinal fluid study but she is disinclined. I think her mother is so disinclined as well but conversely wants to get to the bottom of this. Again, I do not feel strongly about this because I think significant CNS infection is quite unlikely especially given the MRI findings and the lack of meningismus and similar symptoms.

(3) The balance of my plan will resume what we had intended before, that being the use of triptans for migrainous headaches but I will also add amitriptyline 10 milligrams to titrate upwards to 50 milligrams with weekly steps presuming she tolerates it and presuming it is necessary to get her headaches under control.

(4) I would like to see her back in three to four weeks.

EXHIBIT 5
PAGE 14

Sincerely yours,

[signature]

Kirk L. Weller, M. D.

KLW:vo

Axert 6.25mg prn Migraine HA.
May repeat in 2°. -
#6 refill x 3 Rx

Pt's mom Melinda informed. Did not want Rx for Axert. Will call if they change mind. MD

The Oregon Clinic- Gastroenterology Division
10535 NE Glisan, Suite 200 Portland, OR 97220
Main: 503-258-1755 Rx Line: RX VM: 503-963-2704
Fax: 503-258-1772

Talia E Hinman 17 Year Old Female DOB: 05/15/1987 TOC Chart No:40379500
Referring Provider: Anthony Gay Primary Ins: John Alden
ID#: 542589588 Secondary Ins: Secondary ID#:

06/15/2004 - Office Visit: Diarrhea
Provider: Jeffrey Albaugh MD
Location of Care: The Oregon Clinic- Gastroenterology Division

REFERRING PHYSICIAN: Kirk L. Weller, M.D.

HISTORY OF PRESENT ILLNESS: This 17-year-old white female developed the rather acute onset 4½ months ago of postprandial vomiting, diffuse abdominal pain, and increasing headaches. She was initially thought to have a flu syndrome. She was treated with a course of amoxicillin for suspected sinusitis in March 2004, she states, with improvement. Her symptoms returned after the amoxicillin was discontinued. However, she failed to improve following a second course of amoxicillin. She was seen subsequently by Dr. Marshall of Pediatric Gastroenterology at Emanuel Hospital. Apparently upper endoscopy was done that was normal. We have a copy of a CT scan from Providence Hood River dated April 23, 2004, that was normal. A May 11, 2004 CBC was unremarkable. Records indicate that chemistry profile was unremarkable.

In recent weeks the patient has had a variable bowel habit. She has periods of nonbloody diarrhea, alternating with constipation. She may have diarrhea for up to a week and then no stools at all for 2-3 days. She notes no blood in her stool. She suffers from cramping abdominal pain, rather diffuse in nature that can be improved temporarily by having a bowel movement. Her appetite is fair to good although she states she has lost 25 pounds in recent months. She complains of easy fatigability and low-grade temperatures intermittently between 99 degrees and 100 degrees.

She describes difficulty with sleep and frequent early morning awakening. It has been suggested in the past that her symptoms might be "psychosomatic" in origin. She has undergone counseling without specific diagnosis that she or her mother are aware. No medical therapy has been prescribed. She states that her last menstrual period was about four weeks ago and was unremarkable. She states her last pelvic examination was in January 2004 and was unrevealing. She does believe that she has ovarian cysts. The patient and her family have sought the assistance of a naturopath recently. It has been suggested that there may be some abnormalities of her cortisol production.

PAST MEDICAL HISTORY:

SURGERIES: None.

MEDICAL ILLNESSES: None except discussed above.

MEDICATIONS: Elavil had been prescribed recently, 20 mg at bedtime for headaches but she was intolerant and it was discontinued.

ALLERGIES: None.

FAMILY HISTORY: Negative for colonic neoplasia, inflammatory bowel disease, or irritable bowel syndrome.

HABITS: Smoking - nonsmoker. Alcohol - denied. Milk - one glass daily.

PERSONAL HISTORY: The patient is single and she is a student.

REVIEW OF SYSTEMS:
GENERAL: A 25-pound weight loss over the last 3-4 months, easy fatigability, periodic low-grade

EXHIBIT 5
PAGE 15

JUN 29 2004

The Oregon Clinic- Gastroenterology Division
10535 NE Glisan, Suite 200 Portland, OR 97220
Main: 503-258-1755 Rx Line: RX VM: 503-963-2704
Fax: 503-258-1772

Talia E Hinman 17 Year Old Female DOB: 05/15/1987 TOC Chart No:40379500
Referring Provider: Anthony Gay Primary Ins: John Alden
ID#: 542589588 Secondary Ins: Secondary ID#:

temperatures up to 100 degrees.
CARDIOPULMONARY: Occasional cramping chest pain. Cough is denied.
MUSCULOSKELETAL: She complains of periodic arthralgias involving her hips and back. Intermittent muscular myalgias.
NEUROLOGIC: Chronic headaches as discussed above, currently under the evaluation of Dr. Weller of neurology. Feelings of depression, apparently no formal diagnosis or treatment, however.
Review of systems is otherwise negative except as discussed above.

PHYSICAL EXAMINATION:
GENERAL: A healthy-appearing white female in no acute distress. She is accompanied by her mother.
VITALS: Blood pressure 116/62. Pulse 88 and regular. Weight 122 pounds.
HEAD & NECK: Thyroid is not palpable, no adenopathy.
CHEST: Clear.
BREASTS: Not examined.
CARDIAC: Regular rhythm. No murmur or gallop.
ABDOMEN: Bowel sounds are active. Soft and nontender. No organomegaly or mass.
RECTAL: Unremarkable, including Hemoccult-negative stool.
EXTREMITIES: No cyanosis, clubbing, or edema present.

IMPRESSION: A 17-year-old white female with 4½ months of variable bowel habit, abdominal pain, and questionable low-grade fevers. I think the diagnosis ultimately will be irritable bowel syndrome. However, I certainly think that Crohn's disease must be considered and ruled out. Partial obstructing neoplasm is be a remote consideration. Consider chronic giardiasis. Consider celiac disease. Family raises the issue of adrenal insufficiency and conceivably that could be causing some of the patient's complaints, although again I think that is a remote consideration.

PLAN:
1. Repeat CBC, chemistry profile, sedimentation rate, and thyroid function studies. Celiac antibody studies. Serum cortisol.
2. Stool specimens for Giardia as well as ova and parasites.
3. Request old records from Dr. Marshall.
4. Empiric trial of Donnatal one tablet four times daily #40 prescribed.
5. Call with progress in about 10 days. If the patient is unimproved with the Donnatal and all her studies are negative, then we will proceed on to colonoscopy and possibly repeat upper endoscopy with small bowel biopsy.

JEFFREY S. ALBAUGH, M.D.
JSA/gsa/cal/vb

cc: Kirk L. Weller, M.D.
Anthony S. Gay, M.D. ✓

Signed by Jeffrey Albaugh MD on 06/24/2004 at 6:03 PM

EXHIBIT 5
PAGE 16

Oregon Health & Science University
Hospitals and Clinics
3181 SW Sam Jackson Park Rd.
Portland, OR 97239-3098
503-494-8311 or 1-800-245-6478

OUTPATIENT CONSULTATION REPORT

Account No. J[illegible]55330

Medical Record No: 01-87-79-30

Name: Hinman, Talia Elise

Birth Date: 05/15/1987

Referred From and Faxed To: Anthony S. Gay, M.D., Columbia Gorge Family Medicine

Referred To: Not dictated.

Consulting Physician: John M. Townes, M.D.

Consultation Date: 09/24/2004

Reason for Requested Consultation: Fever, fatigue, weight loss, nausea and vomiting.

History of Present Illness: The patient is a 17-year-old young woman who has had multiple symptoms since beginning of 2003. She states that she began to have problems back in March 2003, when she began to have hip problems and had to decrease her softball playing. She is apparently an allstar soft ball pitcher. She had a rather inactive summer and then beginning in March 2004 she had onset of nausea and vomiting and diarrhea with associated weight loss and headaches with worsening of her hip pain. She has also had pain in her lower back, wrists and knees. She has seen multiple physicians and had an extensive workup. This has included a negative Monospot test in March 2004, repeated negative on April 14, 2004. She had a CBC that had a slightly low white count on March 18, 2004 with a normal differential followup CBC on April 14, 2004, which showed a white cell count of 4.8 with 60% lymphocytes and 4% atypical lymphocytes. She underwent a CT scan of the sinuses, which was negative on April 20, 2004 and a CT scan of the abdomen on April 26, 2004, and both of these were negative. An antinuclear antibody, ANCA, SPEP, RPR and B12 were all negative or normal. Beta HCG was negative. Thyroid function studies were normal. She underwent upper endoscopy with studies for H. pylori that were negative. No abnormality was seen. A Lyme disease antibody test was negative. She has had subsequent testing with a C6 peptide that was negative. She has been seen by a gastroenterologist who has suggested perhaps obtaining a lower colonoscopy and upper endoscopy with small bowel biopsy. This has not been performed so far. She did have stool specimens for Giardia and ova and parasites, which were negative. She has also been seen by Dr. Kirk Weller back in May 2004 who felt that she had a normal neurologic examination. Lumbar puncture was considered, but this has not been done. She has been treated with a variety of different medications including antibiotics and antidepressants, as well as proton pump inhibitors. None of these have been helpful. Her migraine headaches were thought possibly due to oral contraceptives. Her oral contraceptives were briefly held. Her symptoms did not improve, and so she was started back on her contraceptives, Ortho Evra patch.

Her main complaint over the last several weeks has been a severe headache, which is constant in nature, unrelieved by any medication that she has tried. She describes it as a dull ache behind her eyes or sometimes in the left temple that is present at all times with periods of exacerbation. She has had some intermittent diarrhea and constipation. She has not had any bloody stool. She continues to have low back pain and hip pain. She has seen a chiropractor, and he has suggested that her spine is out of alignment, and she has had some spinal manipulation. She has also been to see a naturopath recently who told her that she had adrenal insufficiency. She was subsequently referred to endocrinology and that is Dr. James Beard, and the results of cortisol testing in his lab are not available to me at the moment. She says she was supposed to return for a Cortrosyn stimulating test, but this has not been done. The naturopath also has prescribed a six-day course of antibiotics with 4

different antibiotics including Flagyl, doxycycline and several others and subsequently obtained a urine test, which was sent to Igenex laboratories for Lyme disease. She notes she did feel better after a few days of the antibiotics, but then felt worse again. She describes some low grade fevers, but has not taken her temperatures recently. Her weight initially decreased by about 20 pounds at the beginning of illness, but has stabilized now. Review of systems is otherwise negative.

Past Medical History: Remarkable for a history of high fevers as a child. She had no unusual illnesses. She has never been hospitalized. She has had ankle fractures and rib dislocations as a result of softball.

Family History: Remarkable for the fact that her mother has a prolactin-producing pituitary tumor. Her grandmother died of Hodgkin's lymphoma. She has a brother and sister who are in good health.

Medication: Ortho Evra patch.

ALLERGIES: **NONE TO DRUGS.**

Social History: She is reportedly a gifted and talented student. She is an avid softball player, but has been unable to play recently. She also enjoys snow boarding and playing basketball. She has been hampered in these activities by constant hip pain. She has missed quite a bit of school, because of her illness. She lives near Hood River on a pear orchard. She often mows the grass around the orchard areas. She has some contact with the migrant farm workers. She enjoys walking in the woods and does have a friend who is a logger who gave her a pet owl. Late in 2003, the owl died after about a week in captivity. They noticed that the owl had some ticks on it. The patient was apparently abused by her natural father as a child. He has subsequently passed away. She is in a monogamous relationship with a man who is in his early 20s. This relationship began about the beginning of this year. He apparently has problems with substance abuse including cocaine and methamphetamine. He is currently taking Vicodin and methadone. He has no history of injection drug use. The patient herself has tried methamphetamine, cocaine and marijuana. She denies current use. She smokes occasionally and denies alcohol use. Her brother and father are avid hunters and have brought home bear, elk and deer meat, which she has eaten. She has also eaten bear liver. She always eats the wild game meat well cooked. She has a pet dog, cat, two horses, a rabbit and at various times has had pet skunks, owls, birds and ducks. She has traveled to France, Germany and Switzerland in 2001, Southern California, Florida and a 10 day vacation in Tonga in the South Pacific in 2001. Her older sister is an attorney. The patient is a senior in high school. She plans to go to college, but has not made any plans for which college to apply to.

Physical Examination: She is a pale, depressed appearing young woman in no distress. Her height is 67-3/4 inches. Weight is 121.5 lbs. Temperature is 98.4. Pulse is 96. Blood pressure is 104/60. HEENT: She has a normal hair pattern. Her hair is slightly thin. She has pock marked forehead with scattered acne lesions. The oropharynx is normal. There is no oral thrush. There are no obvious dental caries or abscesses. The pupils are equal and reactive. There is no scleral icterus. There is no conjunctival petechiae. The funduscopic examination is normal. The right tympanic membrane is obscured by cerumen. The left tympanic membrane has a normal light reflex. There is no mastoid or sinus tenderness. The neck is supple without significant adenopathy. There is no axillary or inguinal adenopathy. Chest is clear to auscultation. Cardiovascular examination reveals a nondisplaced PMI. There is a split S2 and a normal S1 without murmur. The abdomen is flat, soft and nontender. The liver and spleen are not enlarged. There are no masses palpable. The spine has some mild tenderness throughout, most notable in the lumbar spine region, but there is no focal point tenderness. Extremities: No clubbing, cyanosis or edema. There is a

bruise over the left knee. There is no joint effusion. Her thumbs are hypermobile. There is no pain with internal/external rotation at the hip. There is some pain in the rectus femoris tendon insertion site with flexion and palpation at that site. Neurological examination is grossly nonfocal. Her mental state is normal. Speech is appropriate. Cranial nerves are intact bilaterally. Strength is 5/5 throughout. Gait and station are normal. Detailed sensory examination was not performed.

Impression:
1. Headache.
2. History of intermittent diarrhea.
3. Joint pains, i.e. arthralgias.

Given the absence of any signs of inflammation on examination or by previous laboratory test and the lack of clinical progression over a one-year period makes an infectious disease cause of this patient's illness unlikely. It is conceivable that she did have mononucleosis syndrome back in March 2004, when she had 4% atypical lymphocytes. It is possible that the Monospot test was falsely negative and that what we are dealing with here is a chronic sequelae of Epstein-Barr virus infection, which should resolve on its own. Other possibilities include cytomegalovirus virus and toxoplasmosis, given her history of consumption of bear meat. An inflammatory process in the cerebrospinal fluid is conceivable, and this should be excluded with a lumbar puncture given the chronicity of her headaches. It is possible that she has an autoimmune process or other chronic meningitis, although I believe this is doubtful.

Plan: I will repeat the CBC and differential and obtain serologies for Epstein-Barr virus, CMV and toxoplasmosis. I will repeat the C-reactive protein and sedimentation rate and obtain a chest x-ray to rule out mediastinal adenopathy consistent with either sarcoidosis or lymphoma. I will see the patient back in two weeks time and discuss the results of the above tests and discuss her illness again with her at that time.

John M Townes, M.D

JMT/x30
D: 09/24/2004
T: 09/27/2004 6:31 A
003043375

cc: Anthony S. Gay, M.D., Columbia Gorge Family Medicine, 1108 June Street, Hood River, Oregon,
97031, telephone number (541) 386-5070, fax number (541) 386-7190

EXHIBIT 5
PAGE 19

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.
DOCTORS BERGSTROM, BEARD, NEIFING, SUH, BOOKIN, MITTAN & GRADY

PROGRESS RECORD

Name Talia Kennon

Chart No.

A - Analysis
P - Plan
PS - See Flow Sheet

Date	Problem	Progress Record
7-7-04 Beard		NP Ref. by Dr. Tony Gay re fatigue + GI symptoms, wt. loss Nausea onset late February. She went to clinic in late March c/o HA's, nausea, vomiting. Was given Protonix + augmentin; felt much better until the week was over. Later, tried Tylenol again c no evident benefit. Headaches: had these all day every day for 3 months. This has been better of late. Nausea/vomiting: This was bad for a couple of months, gradually improved in May. Constipation/diarrhea: Started up in early May. It's improved on its own. Still nauseated more than nl; ~~no~~ headaches (she never used to have these); heat intolerant (nauseated); fatigued prominently; weight loss. She lost ~30 lbs; has regained about 8 of these. There's been no ↑ in pigmentation, and today she's paler than her usual (pre-illness). Labs - include: - Upper endoscopy c neg H. pylori - salivary cortisol profile, normal x higher than nl at bedtime - neg pregnancy test - nl TSH & CBC (in April) - 40% atypical lymphocytes (April) - normal head CT, abd. CT. EXHIBIT 5 PAGE 20 cont —

DOCTOR... BERGSTROM, BEARD, NEIFING, SUH, BOOK..., MITTAN & GRADY

PROGRESS RECORD

Name Talia Hinman

Chart No.

A - Analysis
P - Plan
PS - See Flow Sheet

Date	Problem	Progress Record
7-7-04 Beard		—cont—
		She's athletic; softball since age 8, practices 11 mo/yr. Plays basketball x years. So this is all a huge change from a very high energy state.
		A- Severe viral syndrome – gastritis – bowel syndrome – meningitis symptoms – arthralgias – general fatigue – leukopenia c̄ atypical lymphs – low-grade fever.
		I would R/O adrenal insuff. based on the nl. lytes, ~~&~~ nl. adrenal (salivary cortisol) profile. Similarly, thyroid dysfunction is ruled out by nl. tests and couldn't explain all this.
		P- Reasonable to screen for HIV and check CMV titers.

EXHIBIT 5
PAGE 21

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.
DOCTORS BERGSTROM, BEARD, NEIFING, SUH, BOOKIN, MITTAN & GRADY

PROGRESS RECORD

Name: Talia Hinman

Chart No. ______

A - Analysis
P - Plan
PS - See Flow Sheet

Telephone Record

Date of message: 7/25/4 Time of message: 3:15 AM/PM For Dr. JCB/ma
Caller: Melinda mom Relation to pt: Pt. name: Talia Hinman Age:
Message: would like to start getting back in shape but joints so stiff still pass use antiinflam or do we have to just wait it out?
Caller's phone no. 541 354-2365 or 541 806-2900
Call back at: AM/PM Pt. Chart No. Initials

Physician's orders/Followup action: Is this for you or pcp
Cautious use of NSAID OK. But if feels bad, don't do it in general.
Call back? Yes ✓ No Chart slip? Yes No Followup Completed AM/PM Initials

AUG 16 2004
Beard

Malaise, GI trouble, etc.
- Stomach complaints absent.
- Thyroid - fT4 was low, fT3 OK, TSH 3.49.
  A - prob. euthyroid sick
  Expect some normalization
  P - Recheck TFT's
- Viral: HIV, CMV Abs neg.
- arthralgias - knees, back, neck all sore. No knee enlargement.
- Headaches - back to daily

A - Rheumatologic disorder vs viral infection c̄ persistent effects
- Improved in GI sense, but very limiting joint/muscle sympt[illegible]
P - Consult rheumatology
- ACTH stim to F/U on low random (2.5 at 5 PM)

EXHIBIT 5
PAGE 22

Columbia Gorge Family Medicine

Patient's Name Talia Hinman **DOB** 5-15-87

Date: MAY 19 2004	**Time:** 0935	**Temp:** 97.8	**B/P:** 92/58	**P:**	**R:**	
			Vision with: R	L		
WT: 122	**HT:**	**HC:**	**without:** R	L	**By:** AB/mr	
Lab:			**Meds:**			

HINMAN, Talia

5-19-04 Talia is brought in by her mother. They express frustration that she has continued to have problems for so long and the specialists have not seemed to find anything. She is 17 and basically since about March 1st, she has had nausea, vomiting, low grade fever, stomach cramps. She states now she is nauseated all the time, but only vomits 2 times a week. She has had headaches all day long that starts at the bilateral temple and goes back to the right occiput. She has low grade fever, often feels hot and nauseated and when they check her temperature, it is usually 99.5, occasionally up to 100, occasionally down to 98.6. For the last week, she has had increasing somnolence. She is sleepy all the time and she is sleeping about 20 hours per day. She is a junior in high school. They had to take her out of high school and she will have to do some college classes this summer to keep from getting behind. She is suppose to be working at Taco Del Mar, but she is unable to work regularly.

Mother has a list of questions. Talia had hip pain for about 6 months prior to this illness. It was felt to be a bursitis. Physical therapy was not especially helpful. She had an MRI, which showed a possible right ovary cyst. She was placed on birth control pills. Eventually that got her cycles regulated, but then stopped them in April thinking that might be contributing to her recent symptoms, but it was to no affect.

She has had multiple studies by me. She was seen by the local ENT, who felt it was not primarily an ENT problem. She was sent to Melissa Burchett, and Dr. Marshall's office where she had endoscopy. H. pylori antibody had been obtained April 14th which was negative. Previous to that, she had Augmentin empirically treating for symptoms of sinus infection and in late April or early May, she had endoscopy and supposedly had biopsies that were negative for H. pylori infection. Endoscopy and biopsy reports I have not seen. She was then seen by Dr. Weller, neurologist. Several labs were ordered, all of which are normal. She was given samples of Axert to try for migraines, but she has not tried them yet and she is seeing him back in the next week and a half to consider a lumbar puncture, looking for cryptococcal or other CNS infection. Dr. Weller brought up the question of seeing an infectious disease specialist and I would agree that is appropriate. It has also been suggested that we delve more into psychiatric issues.

Talia's mother, Melinda, had a common law husband who was Talia's father. They were together about 6 years. Talia was abused by him and they separated when Talia was about age 5. She then had some court supervised visits until about age 9 and has not seen him since then. A year and a half ago, he died in a sky diving accident and Talia really doesn't feel that she has any issues regarding this. Her mother married Talia's step-father, Dale, in 1991 and for all intents and purposes he is Talia's father and she states she has a good relationship with him. They have agreed to see a counselor and even consider anti-depressant to see if that would help her feel better, though they never felt that was a primary issue.

When Talia first saw me in March, she was smoking one cigarette per day, drinking 3 pops per week. She was not doing alcohol or drugs, though she had slight amount of remote drug use. She has not used anything since then in an effort to try to be healthier. She states her bowel movements tend to alternate between 2 weeks of diarrhea and 2 weeks of constipation.

MEDS: Nexium 40 mg q.d. taking occasionally
Ibuprofen 200 mg 1 per day for back pain, minimal help
Midol for headache, minimal help, takes rarely
Muscle relaxer from grandmother, took 1 and helped with back pain

EXHIBIT 5
PAGE 23

O: Talia is pale and quite fatigued and she looks more ill than her last visit. She has lost another 5 1/2 lbs, total of 22 lbs since February. BP 92/58, T 97.8.

EYES: PERRLA, EOMI. Fundi benign. No photophobia.
ENT: Ears normal anatomy, white TMs. Good mobility, no fluid. Nares have 1+ erythematous mucosa, scant clear drainage. Oropharynx has trace draining clear mucus, trace edema, no erythema. She has 2+ tenderness over the left greater than right maxillary sinus areas.

Columbia Gorge Family Medicine

30
~~80~~) **TALIA HINMAN** **DOB: 05-15-87**

HINMAN, Talia
10-8-04 17-year-old female, senior in high school, who comes in with her mother to review several concerns. Since she was seen here in May, they have been to Dr. Beard, endocrinologist, who felt she had some type of viral syndrome and had an aftermath that should gradually get better in the next several months. They went to Dr. George Kirby, naturopath, and went on vitamin supplements, try to get her to rest, have a curfew during the summer. She states she slept well, rested, but really her symptoms didn't change. She went to Dr. Czarnecki in The Dalles, who they liked and was working on some musculoskeletal things and sent them to Rob Schwartz. They did a Lyme disease, ELISA which was negative. A Lyme disease C6 peptide which is pending. Dr. Schwartz felt she had some TMJ and referred her to someone with a mouth guard, but that is not helpful. They have made an appointment with a specialist in San Francisco for possible chronic undiagnosed Lyme disease and were wondering my opinion as to whether they should keep that appointment. They are leaving in 2 days. The gastroenterologist diagnosed irritable bowel syndrome. She states her stomach did better in June and July, but now her symptoms have recurred. She has always been alternating constipation for 1-3 days and then diarrhea for 1-3 days, nothing seemed to make much difference. She tried Amitriptyline for 2 weeks, but it made her too sleepy and the side effects never got better. She tried off dairy for 2 weeks and it made no change. She tried Metamucil, she thinks helped, but then stopped it and does not recall why. She had stool cultures and stool studies that were all negative. She was seeing Dr. Wade for counseling and according to the patient he states she has a good psychologic attitude. She was going once a week, but recently going every 3 weeks. She states recently she had some flu symptoms with vomiting and she took some Donnatal which was helpful with that and those symptoms have gotten better. She is using Ortho-Evra patch and her periods are once a week. It has been suggested that she have colonoscopy, but that has not yet been done and possible lumbar puncture, but felt it would only be documenting that she was normal and not finding any intervention, so they haven't pursued that. She recently saw Dr. Townes, Oregon Health Sciences University Infectious Disease and he ordered some tests. They have an appointment on October 15th to review those results and consider the next recommended intervention. Recently she took Imitrex 50 mg tablets which helped with her migraine headache. The headaches did not completely go away, so after 2 hours she took a second tablet and it was completely gone. She states she gets migraine headaches about once a week usually from bright lights, sunshine when she forgets her sun glasses, but she gets daily mild headaches, which she states are definitely more of a muscle tension behind her eyes.

Her main complaints are hip pain, back pain, neck pain, headache, alternating diarrhea and constipation, generalized fatigue. She states she has been eating well. Her weight has been good. She is hoping to gain 5 more pounds. She states her moods have been pretty good. Mother confirms she has had a pretty good attitude.

O: WDF, appears pale and fatigued, but cheerful. Quite socially appropriate and pleasant. She was able to track well and follow recommendations well and is quite organized and intelligent. Her mother seems slightly more distressed and had little difficulty remembering things as well as her daughter.

EYES: PERRLA, EOMI.
ENT: Ears normal. Mouth and throat clear.
NECK: Supple without nodes.
LUNGS: Clear.
HEART: RR&R without murmur.
ABDOMEN: Benign.
SKIN: Pale, but no lesions.
MUSC: She has extremely hypermobile joints, especially her thumbs. She has good flexion of the lumbar spine and hips and on ambulation, she has good alignment. She tends to have tight pectoralis muscles, rounded shoulders with winging of the scapula. Forward neck posture with tight neck muscles. Her jaw seems to open normally without clicking or pain, but she does not have the normal curvature of the cervical spine.

A: Chronic hip pain, back pain, neck pain, daily tension headaches, migraine headaches once a week, chronic fatigue and irregular bowel movements.

P: Suggested she should keep follow-up with infectious disease. It was up to the patient as to whether they keep this consult I San Francisco. Suggested she could consider an appointment with Joan Laurance to work on nutritional therapy. Recommended she start now with Bret and/or Bettina for physical therapy to work on her hips, shoulders and neck and if she is not progressing with that, will go to Dr. Illo, NUCCA chiropractic for cervical dysfunction and headaches. If that is not effective, consider rheumatology appointment and she will have to discuss with ID specialist and neurologist, whether she should proceed with lumbar puncture and with gastroenterologist about whether she should proceed with colonoscopy. Suggested she recheck with me in 3 weeks to see how she is doing with the physical therapy. **Rx for Imitrex 100 mg 1 po prn migraine, may repeat in 2 hours; maximum of 2 per day, #18.** She will keep track of how that works. Tony Gay, M.D./jw Dictated, but not read.

EXHIBIT 5
PAGE 24

Columbia Gorge Family Medicine

3)
~~(81)~~ **TALIA HINMAN** **DOB: 05-15-87**

Refill - Vicodin 10/325 (generic) - #30 — Filled in to Walmart (Originally by Dr. Paul Czarnecki)
8/12 - A12 8/17 Norco 10/325 - #30.

Date: OCT 29 2004	**Time:** 1009	**Temp:**	**B/P:**	**P:**	**R:**	
			Vision with: R	L		
WT: 129	**HT:**	**HC:**	**without:** R	L	**By:** MB/MA	

Lab: **Meds:**

HINMAN, Talia
10-29-04 After our last visit here, Talia and her mother went to San Franciso and stated it was quite helpful. They saw Christine Green at Dr. Stricker's clinic in San Francisco. They felt she had late stage Lyme disease. They did about 12 vials worth of blood to test for associated problems and also to check for possible Epstein-Barr virus/history of mono. They recommended they would probably want her on antibiotics and family is here wondering if I would be able to do that, or if they will have to go back to San Francisco for that. Talia is excited to have something helpful to fix her problems. The San Francisco doctors did recommend they start her on a pro-biotic now to prevent side affects from antibiotics and also wanted to get copies of her x-rays and brain MRI. Talia states she gets frequent headaches, occasionally migraines. She has used Imitrex 100 mg, which has helped for the migraines. One time she had to repeat it, the other time she didn't. She has been to physical therapy 1 out of 2 times and she thinks it is helpful for her hip.

O: WDF, appears pale and fatigued and is yawning frequently, but she is cheerful, has good eye contact and is social.

EYES: PERRLA, EOMI.
MUSC: She still has hypermobile joints. She is able to achieve normal posture.

A: Chronic hip pain, neck pain, headaches with migraines and tension headaches, chronic fatigue

P: Advised them that I am not aversed to them getting care in San Francisco, but will have to see their recommendations before I agree to her getting therapy here and mother was comfortable with that. We will send them copies of x-ray reports and also get MRI reports from Epic in Portland to send directly to San Francisco doctors. Reviewed the other findings and recommendations from last visit and they could consider going to Rosauer's to get acidophilus/pro-biotics or appointment with Joan Laurance to consider more formal consult. Mother will advise of their response. Tony Gay, M.D./jw Dictated, but not read.

2/22/04 RUR Faxed to WM per KD — kw

PATIENT PHONE CALL

Message For TG — URGENT ☐ Yes ☐ No — mb

Patient's Name Talia Hinman — Age — Weight — call #

Caller M — Home Phone — Work Phone 288-2900

MESSAGE: Talia is on high doses of antibiotics Dr. Green said to have liver + Kidney Function tested. They are still waiting for notes from Dr Green in Calif. do you want to order these?

Date 1/26/05 Time 340 pm By M Hines

RESPONSE:

- OK

1/27/05 pt's mom informed Talia to go to out pt labs for CMP + Liver panel per TG/KW

By (F)

EXHIBIT 5
PAGE 25

Columbia Gorge Family Medicine

32 052) Patient's Name Talia Hinman DOB 05.15.87 MS

'05 refill request faxed to WM per TL ABMA

HINMAN, Talia
7-15-05 Mother had Dr. Christine Green fax me a note from early July, which recommends Talia be placed on **Rocephin 2 grams IV q.d. x 60 days.** We made an appointment for Talia to come in on Monday, July 18th to talk about risks and side effects. She needs an H&P and orders sent over to infusion services. Will **start with a peripheral IV and then eventually switch to a pick line or a portacath. She will have to go to the ER on Saturday and Sunday.** Talia is working at Sub Shop #15 from 11:00 a.m. to 3:00 p.m. this summer and hopefully going to Ashland, southern Oregon college in late September. Tony Gay, M.D./jw Dictated, but not read.

Date: JUL 18 2005	Time: 1043	Temp:	B/P: 110/60	P:	R:
			Vision with: R	L	
WT: 130	HT:	HC:	without: R	L	By: AB/MA
Lab:			Meds:		

HINMAN, Talia
7-18-05 18-year-old female who has been diagnosed with third stage Lyme disease. She was placed on Amoxicillin and Zithromax on November 19th. About May 15th she was switched from Zithromax to Minocycline and she also had a 2 week course of Flagyl some time during that treatment. She stopped the Amoxicillin 2 weeks ago and is just on Minocycline for antibiotics now. She has made good improvement with less vertigo, less nausea, less fatigue and significantly less headache. She states now she is no longer getting migraines, but she is still getting lots of mild headaches. She is still bothered by difficulty with poor memory, forgetfulness and light sensitivity. She does get more fatigued during the hot weather. She states her moods have been good and she has gained 5 lbs. and she is at her goal weight. She states her main concern is that the joint pain in her neck, low back and hips have not really changed since her treatment and comes in today to get set up for IV Rocephin.

She has been seeing Dr. Christine Green every 12 weeks in San Francisco and has a phone call appointment with Dr. Green every 6 weeks.

MEDS: **Probiotic takes daily remembers**
Prilosec takes once every 2 weeks
Minocycline since about May 15th
Amoxicillin, DC'd 2 weeks ago
Imitrex prn migraines, none recently

HABITS: Alcohol none. Coffee 1 in the morning 3 days a week. Cigarettes 1 per week. Marijuana every other day since graduation, June 10th.

She states her periods are once a month, last one was 3 weeks ago. She uses condoms for birth control. She is sexually active with her boyfriend.

REVIEW OF SYSTEMS: She has had hay fever symptoms for the last few weeks with lots of sneezing and runny nose and she has had a lot of belching which she attributed to long-term antibiotics.

She had a full physical, Pap smear, breast exam with Dr. Ellis in January and patient tells me that was normal.

O: WDF, pleasant in NAD.

EYES:	PERRLA, EOMI. Fundi benign.
EARS:	Normal anatomy. White TMs. EACs are clear bilaterally.
NM&T:	Nares have 1- erythematous mucosa, 1- clear drainage. Oropharynx is normal.
NECK:	Supple without nodes. No thyromegaly.
LUNGS:	Clear. Normal breath sounds. No wheezing, rales or rhonchi.
HEART:	RR&R without murmur. No carotid bruit. No JVD.

EXHIBIT 5
PAGE 26

Columbia Gorge Family Medicine

(33) TALIA HINMAN **DOB: 05-15-87**

-18-05 Dictation continued:

ABDOMEN: Normal. No organomegaly. Nontender. Normal bowel sounds in all quadrants. No masses.
MUSC: She has significant ligamentous laxity. She has flexible pes planus. She has frequent clicking of her joints during the exam and frequent yawning during the exam.
SKIN: Clear. She has slight hyperpigmentation on the left hip where she states she had a rash that she attributed to Lyme disease. There is no acute change there now. No new rashes.
NEURO: Screening neurologic exam is normal.

UA negative. Blood pending.

A: 1. 18-year-old female with third stage rheumatologic and neurologic Lyme disease

P: PAR discussion regarding treatment options. Per Dr. Green, we will start **Rocephin 500 mg IV q.d. x 3 days; 1000 mg q.d. x 3 days, then 2 grams q.d. x 60 days.** She was given orders to take to the Infusion Clinic where they will start with a peripheral IV and switch to either a Portacath or Picc line. Will also start on **Actigall 300 mg b.i.d. to reduce the risk of gallstones.** She has an appointment with Infusion Services tomorrow morning at 9:00 to get started on this and will have to get her weekend shots at the ER. Also, appointment with Tom Moline physical therapy to work on some muscle strengthening, muscle balances, etc. Recheck as per usual with Dr. Green and here in one month. Tony Gay, M.D./jw Dictated, but not read.

FAX: Infusion Services at Providence Hood River Memorial Hospital, including chart note 10-8-04 and labs
FAX: Christine Green, M.D. (415) 399-1057, including chart note 10-8-04 and labs
} Faxed 7/19/05 tM

19/05
LETTER SENT Re: TSH, Ftd CMP, Lipid panel, CBC (OK) rec TG

Date: AUG 17 2005 Time: Temp: B/P: P: R:
Vision with: R L
HT: HC: without: R L By:
BMI: N/S ETG/yr Lab/Meds: Letter Sent RE: N/S g

HINMAN, Talia
9-2-05 Phone Call

Infusion Center states she has had diarrhea for one week, 6 times a day. She is on long-term IV Rocephin. She is already on probiotics. I suggested a stool for C. difficile, also O&P and C&S and also make sure she pushes fluids while waiting. Tony Gay, M.D./jw Dictated, but not read.

Date: SEP 13 2005 Time: 0835 Temp: B/P: 100/62 P: R:
Vision with: R L
WT: 127 HT: HC: without: R L By: AB/MA
BMI: Lab/Meds:

HINMAN, Talia
9-13-05 Talia has been diagnosed with third stage rheumatologic and neurologic Lyme disease. At the end of July, she was started on Rocephin. She tells me that she has done 48 out of 90 days and has 42 days remaining. Her Rocephin is 2 grams IV q.d. She was also started on Actigall 300 mg b.i.d. to reduce the risk of gallstones. Over the last few weeks, she has been having symptoms where her chest and neck are severely itchy and she has stuffy nose during the 30 minutes of her IV and for about 10 minutes afterwards. We recommended Benadryl premedication. She didn't want to take that because of side effects, so was given Claritin 10 mg po 40 minutes before infusion and it made no difference. We gave her Benadryl 12.5 mg IV before the infusion on Saturday and Sunday the 10th and 11th and states her reaction was much less severe, though she still had that. Yesterday, she received Benadryl 25 mg IV prior her infusion and she had no symptoms, but she was asleep through the infusion, slept until 3:00 p.m. and then couldn't get back to sleep until 3:00 a.m. Infusions are usually 9:00 in the morning.

She states that since starting this treatment she has been feeling much better. She is having very few headaches. Her general fatigue and sleepiness is continuing. Her memory problems, forgetfulness and light sensitivity is much better. Her moods have been good. 5

EXHIBIT
PAGE 27

Columbia Gorge Family Medicine

(34) TALIA HINMAN **DOB: 05-15-87**

13-05 Dictation continued:

Her appetite is good and she states her weight has been good. She has lost 3 lbs. since July visit. She states joint pain tends to have good and bad days, but she has been able to do more activities and is now running. She had a phone call appointment with Dr. Green a few weeks ago and she has an actual office visit in San Francisco in late October after she finishes her 90 days of IV antibiotics.

Patient states she has had chronic problems with her right ear since all of this started. For the last 2 weeks, it has been intermittently plugging and popping and for the last few days she has had a slight cough.

MEDS: Probiotic q.d.
Prilosec, not required
Minocycline, DC'd
Amoxicillin, DC'd
Imitrex, not required
Actigall 300 mg po b.i.d.
Rocephin 2 grams IV q.d.
Benadryl 25 mg IV, prior to Rocephin started increased dose on 9-12
Claritin 10 mg po q.d., restarted on 9-12

O: WDF, lean, pleasant.

EYES: PERRLA, EOMI. Fundi benign.
ENT: Right TM is white and clear, but there is yellow fluid half-way up. No erythema. Left TM is white and clear. Nares are normal. Oropharynx is benign.
NECK: Slightly tender anterior glands on the right.
LUNGS: Clear. Moving air well. No wheezes, rales or rhonchi.
EART: RR&R without murmur.
BDOMEN: Benign. No organomegaly. No tenderness.
MUSC: She still has significant ligamentous laxity, proximal pes planus. Clicking of her joints in her low back, which is able to hyperflex and hyperextend.
SKIN: No new rashes or changes.
NEURO: Intact.

A: **Third stage rheumatologic and neurologic Lyme disease, improving with IV Rocephin**
Itching secondary to IV Rocephin
Right otitis media
Hypermobile ligaments

P: Suggested she continue Benadryl 25 mg IV. If the somnolent side effects are not improving in 2-3 days, would cut to half dose. She will also continue the Claritin 10 mg po q.d. and if her itching symptoms are getting worse or are not tolerated, would need to consider switching to either Claforan t.i.d. or Levaquin 500 mg IV once daily per Dr. Green. For the ear, recommended gargling with salt water and salt water nose spray and OTC Sudafed. If not improving, she will call for Rx of Flonase. Recommended she return to physical therapy to work on her hypermobility and to help with her joint pain and she states she is feeling well enough she will try that now. She will get a CBC and chem panel and will fax all of this to Dr. Christine Green at 415-399-1057.

ADDENDUM: Patient still has a steady boyfriend. They are using condoms for birth control. I asked her to be especially careful and probably add foam to that. Tony Gay, M.D./jw Dictated, but not read.

FAX: Christine Green, M.D. (415) 399-1057 – Faxed 9/13/05

EXHIBIT 5
PAGE 28

Green Oaks Medical Center
450 Sutter Street, Suite 1504
San Francisco, California
415-399-1035
fax: 415-399-1057

10:30
Wants 11-3

January 4, 2005

Call to SO College
Ashland
late 9/05.

Anthony Gay, MD
1108 Tone St
Hood River, Or 97031
541-386-5070
fax 541-386-7190

Dear Dr Gay:

Talia Hinman has done quite well on oral antibiotics for Lyme disease. She was able to graduate with her class although it was difficult overall for her to achieve that goal; she is a resilient and determined young woman and pushed herself through.

Ms. Hinman notes that vertiginous episodes have resolved, nausea is rare and her fatigue significantly improved. Low fevers, nocturnal diaphoresis and rashes have resolved. She can exercise carefully. However she continues to have joint pain in her neck, low-back and hips. She also has neuropathic symptoms in her hip, neck and low back. Headaches have decreased but not resolved.

Talia is planning to go to college in the Fall. Currently the indicated therapy for Ms. Hinman would be intravenous Rocephin, 2grams daily for 60 days for 3rd stage Rheumatologic and Neurologic Lyme. I think it will give the patient the best chance of starting college at 100 percent.

I usually begin Rocephin at 500mg qD for 3 days and advance as tolerated to 2 grams daily. I suggest Actigall (Ursodiol) 300mg 2x a day to reduce the risk of gallstones while on the therapy.

Start IV
Dr Gaston
PICC.

Sincerely,

Christine Green, M.D.

via infusion
pumps.
M-F
Start, Stop, ER.

AR1833

EXHIBIT 5
PAGE 29